

BABY/CHILD NUTRITION QUESTIONS (6–23 months)

Baby's / Child's Name: _____

Baby's / Child's Age: _____

Please circle or write your answers to the following questions:

1. What month is your baby's/child's next doctor's appointment? _____
2. **How do you know when your baby/child is ready to eat?** _____
How do you know when your baby/child is full? _____
3. **If you breastfeed your baby/child:**
How many times in 24 hours do you breastfeed? _____
How is breastfeeding going? (not good) 1 2 3 4 5 (great)
4. **If you feed your baby/child formula:**
How often does your baby/child take a bottle of formula? _____
How many ounces of formula does your baby/child drink at a feeding? _____
What brand of formula do you give your baby/child? _____
Explain how you make the formula. _____
How is formula feeding going? (not good) 1 2 3 4 5 (great)
5. **If your baby or child uses a bottle or a cup:**
 - ♦ **Where are all the places your baby/child takes a bottle or a cup?** *Bed Stroller Car Seat*
Held in someone's arms High-Chair Holds his/her own bottle Other (list) _____
 - ♦ **What does your baby/child drink from a bottle or a cup?**

<i>Water</i>	<i>Rice Water</i>	<i>Hi-C/Punch</i>	<i>Coffee</i>	<i>Breastmilk</i>
<i>Water with Sugar</i>	<i>Cereal</i>	<i>Soda</i>	<i>Tea</i>	<i>Formula</i>
<i>Water with Honey</i>	<i>Skim Milk</i>	<i>Lemonade</i>	<i>Manzanilla/Chamomile Tea</i>	
<i>Water with Karo Syrup</i>	<i>Lowfat Milk</i>	<i>Juice</i>	<i>Pedialyte</i>	
<i>Jell-O Water</i>	<i>Whole Milk</i>	<i>Gatorade</i>	<i>Other _____</i>	
6. **What do you feed your baby/child?** *Family/Table Food Baby Food in Jars Both None*
7. **Which textures of food do you feed your baby/child?**
Pureed Chunky Chopped Soft Pieces Other _____
8. **What foods does your baby/child eat?**

<i>Cold/Hot Cereal</i>	<i>Beef/Chicken/Fish</i>	<i>Fruits</i>	<i>Yogurt</i>	<i>Crackers</i>
<i>Rice</i>	<i>Eggs Yolks Whites</i>	<i>Vegetables</i>	<i>Ice Cream</i>	<i>Candy</i>
<i>Noodles/Spaghetti</i>	<i>Peanut Butter</i>	<i>Beans</i>	<i>Pudding/Custard</i>	<i>Nuts</i>
<i>Tortillas</i>	<i>Meat Sticks</i>	<i>Soup</i>	<i>Popsicles</i>	<i>Popcorn</i>
<i>Bread/Toast</i>	<i>Hotdogs</i>	<i>Cheese</i>	<i>Raisins</i>	<i>Cookies</i>
<i>French Fries</i>	<i>Chips</i>	<i>Tofu</i>	<i>Other (list) _____</i>	<i>Honey</i>
9. **My baby/child uses the following:** *Breast Bottle Cup Spoon Fork Fingers*
10. **I give my baby/child:** *Vitamins Fluoride Iron Drops Medicine None Other _____*
11. My baby/child currently has: *Allergies Wheezing Rash Constipation Diarrhea None*
12. Has your child had a blood lead test? *Yes No If yes, when? _____*
13. What questions do you have about your baby's/child's eating and growth? _____

For Staff Use Only

Date: _____ WIC Staff Name: _____

Participant WIC ID #: _____ Length/Height: _____ Weight: _____

